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ABSTRACT

This booklet, first of a three-volume series, presents an overview of the problems of child abuse and neglect. Discussions focus on child maltreatment from various perspectives, including characteristics of the parents and children, effects of abuse and neglect, a phychiatrist's view of the problem, and a discussion of state reporting laws. The first chapter defines child maltreatment and lists characteristics that may identify an abused or neglected child. A short discussion of the lasting emotional, physical and psychological scars from mistreatment emphasizes the possible long term effects such as mental retardation, loss of hearing or sight, lack of motor control, and speech defects. In Chapter 2, a psychiatrist looks at the "natural history" of child abuse pointing out that most abusive or neglectful parents were themselves victims of maltreatment. The abusive parent is often immature, dependent, lacking in self confidence, socially isolated and unable to deal with family crises. In Chapter 3, the punishment vs. treatment dichotomy in the laws written to deal with abuse is discussed. Some state laws label child abuse as a crime and others treat child abuse as a family problem requiring therapeutic treatment. Aspects of case reporting are also reviewed. (SB)

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CHILD ABUSE AND NEGLECT

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Child abuse thrives in the shadows of privacy and secrecy. It lives by inattention.

—David Bakan
Slaughter of the Innocents

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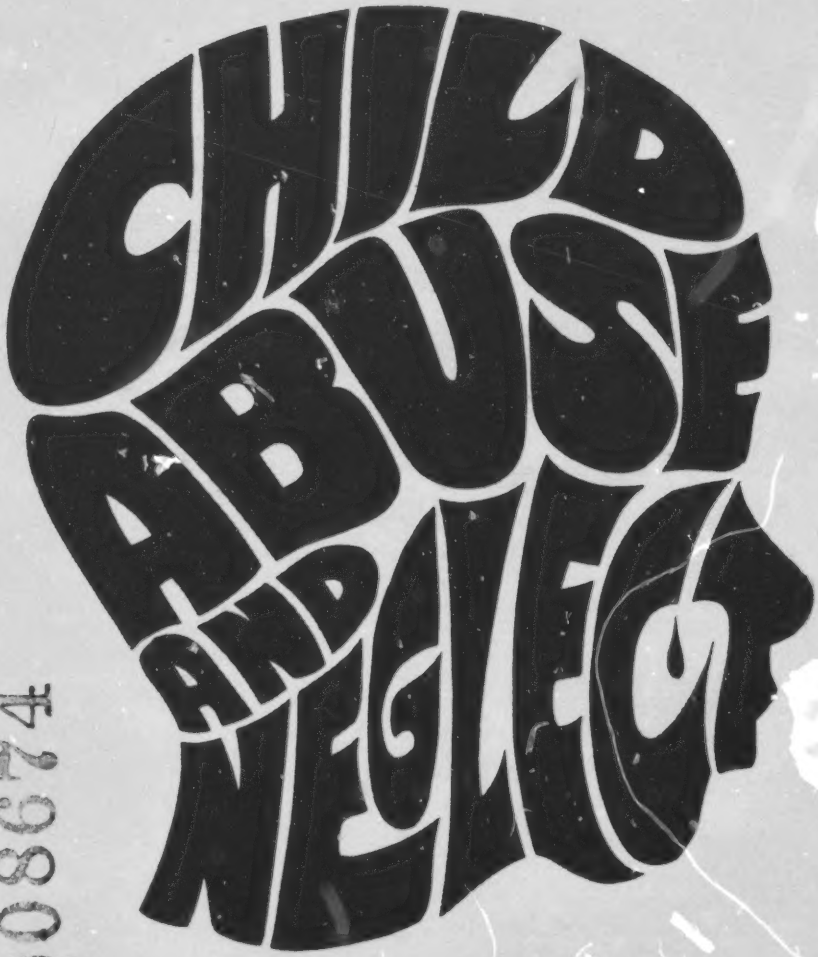
Volume 1
An Overview of the Problem



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The Problem and Its Management

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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In preparing their materials for the series, many of the authors visited agencies throughout the country and interviewed various professionals in the field. Those whose ideas and opinions are expressed here are too numerous to list individually, although each deserves a personal thanks for the interest and information

provided. (To simplify reading, information obtained via personal communication is not specifically referenced; all unreferenced quotes and paraphrased comments included in any of these volumes are the products of personal interviews conducted in 1974.)

The original manuscripts on which the three volumes are based were reviewed by Mildred Arnold, Special Assistant to the Commissioner, Community Services Administration, Social and Rehabilitation Service, DHEW; Vincent De Francis, J.D., Director, Children's Division, The American Humane Association, Denver, Colorado; Phillip Dolinger, Program Supervisor, Child Protective Services, Minneapolis, Minnesota; Elizabeth Elmer, M.S.W., Director, Community Services, Consultation and Education, Pittsburgh Child Guidance Center; Frederick Green, M.D., Children's Hospital, Washington, D. C.; C. Henry Kempe, M.D., Director, National Center for the Prevention and Treatment of Child Abuse and Neglect, Denver, Colorado; and Eli Newberger, M.D., Director, Family Development Study, the Children's Hospital Medical Center, Boston, Massachusetts. While the views and opinions expressed in these volumes are not necessarily those of the reviewers, the National Center on Child Abuse and Neglect extends a special thanks to these and all the other individuals whose ideas and efforts are reflected in these pages.

Foreword

On January 31, 1974, the Child Abuse Prevention and Treatment Act (P.L. 93-247) was signed into law. The act established for the first time within the federal government a National Center on Child Abuse and Neglect. Responsibility for the activities of the Center was assigned to the U. S. Department of Health, Education, and Welfare, which, in turn, placed the Center within the Children's Bureau of the Office of Child Development.

The Center will provide national leadership by conducting studies on abuse and neglect, awarding demonstration and research grants to seek new ways of preventing, identifying, and treating this nationwide problem, and by giving grants to states to enable them to increase and improve their child protective services.

One of the key elements of any successful program is public awareness and understanding, as well as the provision of clear and practical guidance and counsel to those working in the field. It is for this reason that the National Center on Child Abuse and Neglect is publishing a series of booklets—three comprehensive and related volumes (of which this is one), and three shorter booklets dealing with the diagnosis of child abuse and neglect from a medical perspective, working with abusive parents from a psychiatric viewpoint, and setting up a central registry.

While some material in all these publications deals with studies of specific local programs as opposed to generalized approaches, they are not intended to represent categorical or *functional* models upon which other programs should be based in order to be effective. Rather, they are intended to provoke thinking and consideration, offer suggestions, and stimulate ideas. Similarly, the views of the authors do not necessarily reflect the views of HEW.

In the present series, *Child Abuse and Neglect: The Problem and Its Management*, Volume I presents an overview of the problem. It discusses child maltreatment from various perspectives, including characteristics of the parents and children, effects of abuse and neglect, a psychiatrist's view of the problem, and a discussion of state reporting laws. It also examines the many problems that make the abuse and neglect of children so difficult to comprehend and manage — from problems of definition and incidence to deficiencies within our system of child protection.

In Volume 2, the roles of some of the many professionals and agencies involved in case management are discussed: those working with abusive parents; child protective service agencies; physicians and hospitals; the police; and teachers and the schools.

Volume 3 presents a description of community coordination for managing and preventing child abuse and neglect. Within the context of the "community-team approach," various resources for identification and diagnosis, treatment, and education are discussed. The volume includes suggestions for developing a coordinated community program, examples of existing programs, and some current ideas on the prevention of child abuse and neglect.

This series of three volumes includes descriptions of many agencies and programs involved in managing the problem of child maltreatment. Again, each such description is intended as an example rather than as a model.

We hope that everyone concerned with detection, prevention, and treatment of child abuse and neglect will find some, if not all, of these publications of use in the vital work in which they are engaged. We hope, too, that these materials will be of use to those individuals and organizations wishing to become involved.

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The joys of parents are secret,
and so are their griefs and fears.

—Francis Bacon
Of Parents and Children

Chapter 1
A Statement of the Problem

The maltreatment of children is a problem of people living together, interacting in complex ways. It involves not only the tens of thousands of families in which children suffer physical, emotional, and psychological maltreatment each year, but also the countless people who are attempting to understand and manage the problem: members of federal, state, and local governments; those in the health care, legal, and social work systems; taxpayers; and anyone concerned about the welfare of children and families.

In families and societies, as in other systems of human interaction, causes and effects are often obscure. Changes introduced at one point reverberate through the system to produce unexpected results at a hundred other places.

Seen from only one perspective at a time, the picture of child abuse and neglect seems relatively simple to understand. The physician, for example, may perceive it as medical problems to be diagnosed and treated; the policeman, as criminal conduct to be punished. The psychiatrist may view the problem as one of parents in need of treatment, while the social worker may see it as children in need of protection. The sociologist sees social dysfunction; the moralist sees monstrous and unnatural acts. The parents' view tends to be clouded by their desperation, feelings of failure at parenthood, and fears of punishment and criticism rather than help. The children's viewpoint is seldom known.

Seen as a whole—which is how any system must somehow be understood—child maltreatment appears as a tangled web of

myths, half-understood relationships, contradictory approaches to management, tragedies, suspicions, and unknowns. Fragmented perceptions and the divergent results they produce add to the inherent complexity of any attempt to define or deal with the problem.

Definition

Perceptions of what constitutes child maltreatment have differed with time and culture. Practices that we now consider abusive have been accepted in the past as the normal exercise of parental rights, as economic necessity, or as appropriate disciplinary measures.[1]

Up to the twentieth century, children were considered the property of their parents in most cultures. Artistotle wrote that "the justice of a master or a father is a different thing from that of a citizen, for a son or slave is property, and there can be no injustice to one's own property." In ancient Rome, a man could sell, abandon, or kill his child if he pleased. When a Roman citizen was in his father's house, his rights regressed to those of family chattel.

Infanticide has been practiced throughout history, often for economic reasons: to limit family size, to relieve the financial burden of the unwed mother, to assure crop growth by human sacrifice to the appropriate god or gods. Children have been slain, abandoned, and sold into slavery by parents unable to support them, by midwives and wet-nurses greedy for money, and by rulers fearing loss of their power. Other children, perhaps more fortunate than those murdered or exposed, were mutilated to increase their appeal as beggars or freak performers.

Parents and schoolmasters, from the ancient philosophers to the American colonists, believed that sparing rods led to the spoiling of children. Whippings and floggings have been acceptable means of disciplining children in many cultures. American colonists even enacted laws that demanded the obedience of children. In Massachusetts and Connecticut, for example, filial disobedience was punishable by death. The Massachusetts Stubborn Child Law, enacted in 1654, was reaffirmed in 1971 by

the state's highest court, which ruled that children have no right of dissent against the reasonable and lawful commands of their parents or legal guardians. The law was finally repealed in 1973.

Even today, standards of normal and acceptable child care vary by culture and subculture. Practices considered to be mild abuse in some subcultures would in others be completely normal and desirable patterns of child-rearing, everyday discipline, or legitimate folk medicine.[2]

But despite cultural variations, there are norms of acceptable child care in this country. Since the 1960s, all 50 states, the District of Columbia, the Virgin Islands, and Guam have enacted laws to protect children whose parents fail to meet minimal standards of care. In 1974, Congress passed the Child Abuse Prevention and Treatment Act, Public Law 93-247, which defines child abuse and neglect as "the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby."

As the above definition indicates, child abuse and neglect can take many forms. In general, abuse refers to acts of commission such as beating or excessive chastisement; neglect, to acts of omission such as failure to provide adequate food or emotional care. But, as the New York City Mayor's Task Force on Child Abuse and Neglect pointed out, "the line dividing abuse and neglect is a precarious one at best."[3]

Hazy distinctions between abuse and neglect can lead to problems in both reporting and case management. In some communities, for example, similar cases that are differently categorized as "abuse" or "neglect" are accorded quite different types of management. New York City's experience is that "the definitional distinction between neglect and abuse is often based on who [reported] the case . . . rather than what happened to the child" and that "decisions as to the way a particular case is handled are often based on these very same superficial distinctions and labels."[4]

Characteristics of Abuse and Neglect

Recognizing a child's need for protection is obviously more important than determining the form of maltreatment involved. In confronting a possible case of child maltreatment, the operational problem is not how to classify it, but whether or not to report it. Unfortunately, many of those who might report are not acquainted with the characteristics of abuse and neglect, and are therefore not alert to signs of possible maltreatment.

The following lists include both general characteristics of maltreated children and their parents, and some indicators of specific forms of maltreatment. (More specific criteria for medical diagnosis can be found in Volume 2, Chapter 3.) The categories are not necessarily mutually exclusive: any of the forms of maltreatment can occur separately or together. Moreover, the characteristics listed are not proof of maltreatment, since any one or several can reflect situations other than abuse or neglect. But awareness of these characteristics helps in understanding the nature of abuse and neglect and, in practical terms, can help in identifying children in need of protection.

General. Abused or neglected children are likely to share at least several of the following characteristics:

- They appear to be different from other children in physical or emotional makeup, or their parents inappropriately describe them as being "different" or "bad."
- They seem unduly afraid of their parents.
- They may often bear welts, bruises, untreated sores, or other skin injuries.
- Their injuries seem to be inadequately treated.
- They show evidence of overall poor care.
- They are given inappropriate food, drink, or medication.
- They exhibit behavioral extremes: for example, crying often, or crying very little and showing no real expectation of being comforted; being excessively fearful, or seeming fearless of adult authority; being unusually aggressive and destructive, or extremely passive and withdrawn.
- Some are wary of physical contact, especially when it is

initiated by an adult; they become apprehensive when an adult approaches another child, particularly one who is crying. Others are inappropriately hungry for affection, yet may have difficulty relating to children and adults. Based on their past experiences, these children cannot risk getting too close to others.

- They may exhibit a sudden change in behavior: for example, displaying regressive behavior—pants-wetting, thumb-sucking, frequent whining; becoming disruptive; or becoming uncommonly shy and passive.
- They take over the role of the parent, being protective or otherwise attempting to take care of the parent's needs.
- They have learning problems that cannot be diagnosed. If a child's academic, IQ, and medical tests indicate no abnormalities but still the child cannot meet normal expectations, the answer may well be problems in the home—one of which might be abuse or neglect. Particular attention should be given to the child whose attention wanders and who easily becomes self-absorbed.
- They are habitually truant or late to school. Frequent or prolonged absences sometimes result when a parent keeps an injured child at home until the evidence of abuse disappears. In other cases, truancy indicates lack of parental concern or ability to regulate the child's schedule.
- In some cases, they frequently arrive at school too early and remain after classes rather than going home.
- They are always tired and often sleep in class.
- They are inappropriately dressed for the weather. Children who never have coats or shoes in cold weather are receiving subminimal care. On the other hand, those who regularly wear long sleeves or high necklines on hot days may be dressed to hide bruises, burns, or other marks of abuse.

The parents of an abused or neglected child *may* exhibit any of the following traits:

- They are isolated from family supports such as friends, relatives, neighbors, and community groups; they consistently fail to keep appointments, discourage social contact, and never participate in school activities or events.

- They seem to trust no one.
- They themselves were abused or neglected as children.
- They are reluctant to give information about the child's injuries or condition. When questioned, they are unable to explain, or they offer far-fetched or contradictory explanations.
- They respond inappropriately to the seriousness of the child's condition: either by overreacting, seeming hostile or antagonistic when questioned even casually; or by underreacting, showing little concern or awareness and seeming more preoccupied with their own problems than those of the child.
- They refuse to consent to diagnostic studies.
- They fail or delay to take the child for medical care—for routine checkups, for optometric or dental care, or for treatment of injury or illness. In taking an injured child for medical care, they may choose a different hospital or doctor each time.
- They are overcritical of the child and seldom if ever discuss the child in positive terms.
- They have unrealistic expectations of the child, expecting or demanding behavior that is beyond the child's years or ability.
- They believe in the necessity of harsh punishment for children.
- They seldom touch or look at the child; they ignore the child's crying or react with impatience.
- They keep the child confined—perhaps in a crib or playpen—for overlong periods of time.
- They seem to lack understanding of children's physical, emotional, and psychological needs.
- They appear to be misusing alcohol or drugs.
- They cannot be located.
- They appear to lack control, or fear losing control.
- They are of borderline intelligence, psychotic, or psychopathic. While such diagnoses are the responsibility of a psychiatrist, psychologist, or psychiatric social worker, even the lay observer can note whether the parent seems intel-

lectually capable of child-rearing, exhibits generally irrational behavior, or seems excessively cruel and sadistic.

Physical Abuse. More specifically, physically abused children will probably fit some of the following descriptions:

- They bear signs of injury—bruises, welts, contusions, cuts, burns, fractures, lacerations, strap marks, swellings, lost teeth. The list of possibilities is long and unpleasant. While internal injuries are seldom detectable without a hospital workup, anyone in close contact with children should be alert to multiple injuries, a history of repeated injury, new injuries added to old, and untreated injuries—especially in the very young child.
- The older child may attribute the injury to an improbable cause, lying for fear of parental retaliation. The younger child, on the other hand, may be unaware that severe beating is unacceptable and may admit to having been abused.
- They are behavior problems. Especially among adolescents, chronic and unexplainable misbehavior should be investigated as possible evidence of abuse. Some children come to expect abusive behavior as the only kind of attention they can receive, and so act in a way that invites abuse. Others have been known to break the law deliberately so as to come under the jurisdiction of the courts to obtain protection from their parents.
- Their parents generally provide such necessities for the child as adequate food and clean clothes; but they anger quickly, have unrealistic expectations of the child, use inappropriate discipline, and are overly critical and rejecting of the child.

Sexual Abuse. Sexual abuse, a form of physical abuse, ranges from exposure and fondling to intercourse, incest, and rape. Approximately 75 percent of the offenders, usually males, are known to the child or the child's family. Some 90 percent of the victims are girls, from infants through adolescents.

Since the sexually abused child lacks the tell-tale symptoms of battering, sexual abuse is difficult to identify and even harder to prove. Short of the child telling someone, the best indicators are a sudden change in behavior and signs of emotional dis-

turbance. The child, for example, may unexplainably begin to cry easily and seem excessively nervous. Dr. Vincent De Francis reported in 1969 that two-thirds of the children detected in a three-year study of sexual abuse in New York City evidenced some degree of emotional disturbance.[5]

Physical Neglect. Dr. Abraham Levine notes that, to some extent, neglect "defies exact definition, but it may be regarded as the failure to provide the essentials for normal life, such as food, clothing, shelter, care and supervision, and protection from assault."[6] Physically neglected children tend to exhibit at least several of the characteristics below:

- They are often hungry. They may go without breakfast, and have neither food nor money for lunch. Some take the lunch money or food of other children and hoard whatever they obtain.
- They show signs of malnutrition—paleness, low weight relative to height, lack of body tone, fatigue, inability to participate in physical activities, and lack of normal strength and endurance.
- They are usually irritable.
- They show evidence of inadequate home management. They are unclean and unkempt; their clothes are torn and dirty; and they are often unbathed. As mentioned earlier, they may lack proper clothing for weather conditions, and their school attendance may be irregular. In addition, these children may frequently be ill and may exhibit a generally repressed personality, inattentiveness, and withdrawal.
- They are in obvious need of medical attention for such correctable conditions as poor eyesight, dental care, and immunizations.
- They lack parental supervision at home. The child, for example, may frequently return from school to an empty house. While the need for adult supervision is, of course, relative to both the situation and the maturity of the child, it is generally held that a child younger than 12 should always be supervised by an adult or at least have immediate access to a concerned adult when necessary.
- Their parents are either unable or unwilling to provide appropriate care. Some neglecting parents are mentally

deficient; most lack knowledge of parenting skills and tend to be discouraged, depressed, and frustrated with their role as parents.

Emotional Abuse or Neglect. Emotional abuse or neglect is far more difficult to identify than its physical counterparts. Such maltreatment includes the "parent's lack of love and proper direction, inability to accept a child with his potentialities as well as his limitations, . . . [and] failure to encourage the child's normal development by assurance of love and acceptance." [7] The parents of an emotionally abused or neglected child may be overly harsh and critical, demanding excessive academic, athletic, or social performance. Conversely, they may withhold physical and verbal contact, care little about the child's successes and failures, and fail to provide necessary guidance and praise. Though emotional maltreatment may occur alone, it is almost always present in cases of physical abuse or neglect. The emotional damage to children who are physically abused or whose basic physical needs are unattended is often more serious than the bodily damage.

The indicators of emotional maltreatment are often intangible, but sooner or later the consequences become evident. The child may react either by becoming "hyperaggressive, disrupting and demanding . . . shouting his cry for help," or by becoming "withdrawn . . . whispering his cry for help." [8] In a class of psychologically healthy children, the emotionally abused child often stands out unmistakably. Emotional maltreatment has a decidedly adverse effect on a child's learning ability, achievement level, and general development. The strongest indicators are unaccountable learning difficulties and changed or unusual behavior patterns.

Incidence

The problem of child maltreatment has often been compared to an iceberg: reported cases account for the visible tip, but estimates suggest a problem of staggering proportions yet to be revealed.

Ray Helfer estimated the 1973 reporting rate as 350 reports per million population nationwide; this rate yields a figure of more than 70,000 reports for the year. [9] Estimates of actual inci-

dence vary; in fact, most are inconsistent. But all suggest a far more massive problem than that which is reported. According to Vincent De Francis, some 10,000 children are severely battered each year; at least 50,000 to 75,000 are sexually abused; 100,000 are neglected physically, morally, or educationally; and 100,000 suffer emotional neglect.[10] Abraham Levine reports that neglect is estimated to be 2½ to 20 times more prevalent than abuse, with estimates ranging between 500,000 and 2,000,000 incidents a year.[11] David Gil and John Noble, however, place the upper limits of physical abuse at least eight times higher than De Francis' overall estimate and twice as high as Levine's maximum estimate of neglect: approximately 2,500,000 to 4,000,000 incidents of abuse annually, or about 13,000 to 21,000 incidents per million population in the United States.[12]

Despite the contradictions these various estimates present, it is obvious that tens of thousands of children in this country are victims of abuse and neglect each year. It is also clear that there is a gap between the number of reported cases and the actual incidence of maltreatment. Even cases brought to the attention of health care professionals frequently go unreported. For example, in a survey by the Auburn, New York Department of Social Services of 195 cases of children treated in hospital emergency rooms, 26 cases (13 percent) involved "suspicious injuries" that should have been reported. None were. The department concluded that the number of potential abuse cases might be double or triple the number of cases reported.[13] Another study in a hospital in Rochester, New York found that approximately 10 percent of all children under the age of five brought to the emergency room fell into the "battered child" category, and another 10 percent into the category of neglect.[14] Prior to the study's intensive evaluation of these cases, most went unreported.

Further evidence of substantial under-reporting can be found in the experience of several states. In Florida, for example, several measures to improve reporting in 1971—the amendment of Florida's reporting statute, the installation of a central registry and statewide reporting "hotline," and the initiation of a state-run protective service program—produced more than 19,000 reports of child abuse and neglect between October 1971 and October 1972. During the previous year-long period, 17 reports

were filed throughout the state. (See Volume 3, Chapter 4 for a discussion of Florida's reporting experience.)

Myths

At least part of the reason for under-reporting is that it is difficult to accept the fact that parents can nonaccidentally mistreat their children. Child maltreatment violates our most cherished stereotypes of parenthood. Our images of the ever-patient, always caring parent quickly evaporate when confronted with a child hurt by his or her parent. Attempts to rationalize the problem of maltreatment have surrounded it with myths. Among the most common are: abuse and neglect are problems of the poor; abusive parents simply misjudge their own strength; the parents are psychotic.

The facts are different. Children are abused and neglected in families from all socioeconomic levels, races, nationalities, and religious groups. The problem is not limited to racial minorities nor to the poor, even though these groups account for proportionately large figures in reporting statistics. In 1968, for example, the nationwide reporting rate was 6.7 per 100,000 for white children, compared to 21.0 per 100,000 for nonwhites.[15]

Poor families and nonwhite families are reported more frequently than middle- and upper-class whites for several reasons. Members of lower socioeconomic groups are the clients of welfare agencies, municipal hospitals, and out-patient clinics. Compared to middle- and upper-class families, they not only have more contacts with many different types of professionals, but their home lives and problems are also more open to professional scrutiny. In addition, as the head of one hospital's child abuse team noted, even professionals in the social work and medical fields may find it more difficult to report a family with whom they can identify: whites have more difficulty reporting whites, and blacks more difficulty reporting blacks; those of the middle class find it harder to report a middle-class family; and so on. Since most professionals are middle- and upper-class whites, poor nonwhite families tend to account for the greatest proportion of reports.

These facts, however, do not deny the profound effects of social and economic deprivation, housing problems, unemploy-

ment, and subcultural and racial pressures on the lives and behavior of parents who maltreat their children. Any stress can make life more difficult, and the ramifications of poverty and discrimination can aggravate any problem. Such factors are involved to some degree in many cases of abuse and neglect, and they must be considered in every treatment program. When appropriate, remedial measures should be taken through social casework, psychotherapy, counseling, vocational rehabilitation, financial aid, or any other available method of assistance or support.

But no matter how necessary and useful it might be to improve the socioeconomic status of a family, this should not be confused with treating the more deeply seated character problems involved in abusive behavior. Individual acts of abuse may occur when parents are faced with a crisis involving finances, employment, illness, or various other matters; but such crises cannot be considered justification for abuse. Crises are common in the lives of many parents who do not maltreat their children; and, on the other hand, maltreatment can occur in families that are wealthy, well educated, and well housed.

Two other misconceptions about child maltreatment are that the parents, unaware of their own strength, unwittingly injure their children while disciplining them, or that the parents are obviously psychotic. As Kempe and Helfer note, it is incorrect to believe that abuse is caused by parents who simply "don't know their strength." Abusive or neglectful behavior is a complex pattern of parenting behavior; its cause generally involves the childhood experience of the parent, parental misconceptions of the child, and crises in the life of the family which can precipitate incidents of abuse (see Chapter 2). Studies have found that parents who abuse or neglect their children show an incidence of psychoses, neuroses, and character disorders similar to that in the general population; only some 10 percent of the parents exhibit serious psychiatric disorders. Given the necessary combination of circumstances, anyone could abuse or neglect a child.

The Effects of Maltreatment on Children

Maltreatment can leave children with physical, emotional, and psychological scars; it can also result in death. Estimates of

the mortality rate range from 5 to 27 percent.[17] One source notes that 6,000 deaths are officially attributed to abuse each year, but that the actual number may be as high as 50,000 annually.[18] Maltreatment, in fact, is claimed to be the number one killer of children in this country.[19]

Physical injury resulting from abuse can include cuts, burns, bruises, abrasions, contusions, shock, laceration of internal organs, hemorrhage, subdural hematoma, and fractures. Because of their exceedingly fragile tissues, infants are particularly susceptible to physical injuries resulting from even mild abuse. In the physically neglected child, lack of adequate care can result in failure to thrive, skin infections, diaper rash, dehydration, malnutrition, maggot infestation—any of which can range from mild to severe.[20] Depending on the type and severity of maltreatment, long-term physical effects can include mental retardation, loss of hearing or sight, lack of motor control, and speech defects.

Child victims of abuse and neglect have also been found to have learning behavior, and habit disorders. (See Chapter 2 of this volume and Volume 3, Chapter 3 for discussion of some of the emotional and psychological effects of maltreatment on children.) Some maltreated children experience problems such as drug abuse, obesity, teenage pregnancy, and delinquency in later life. Many appear to pattern their adult lives on their past—abusing their own children, and sometimes others as well. According to Family Court Judge Nanette Dembitz, "It is as natural for a maltreated child to grow up to carry a knife as it is for a loved and cared-for child to carry a pen or pencil."[21] Among the more infamous adults who were maltreated as children are Arthur Bremmer, Sirhan Sirhan, James Earl Ray, Lee Harvey Oswald, and John Wilkes Booth.[22]

Although it is not known whether criminal behavior is the rare or common outcome of maltreatment, it is clear that both maltreated children and their parents are in need of help.

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Chapter 2
Child Maltreatment: A Psychiatric View*

Child maltreatment should not be considered a psychiatric disorder in the usual sense of the term. More accurately, it is a problem of abnormal parenting behavior, a distorted and disordered pattern of child-rearing. However, the origin, development, and expression of abusive and neglectful behavior can be clearly described and understood in psychological terms. In this chapter, psychiatric concepts of human development and psychiatric insights into human behavior are used to provide a framework through which one can approach, understand, and work toward alleviating the problem of child maltreatment. Much of Chapter 3, Volume 3, which discusses considerations and problems in treatment as well as various therapeutic modalities, is based on the information presented here.

The "Natural History" of Maltreatment

There is one basic premise that is probably most helpful in eliminating attitudes of anger and punitiveness toward abusive and neglectful parents: their parenting behavior is often the product of their own childhood experiences. Almost without exception, these parents were abused or neglected as children. Like most parents, they rear their children in much the same way they were raised.

In order to understand something of the origin and development of abusive and neglectful behavior, it is important first to look at the two very different meanings of the term "neglect."

*Adapted from the booklet *Working with Abusive Parents from a Psychiatric Point of View*, written by Dr. Brandt Steele for the Office of Child Development in 1974.

One is the common meaning of material neglect—the lack of adequate food, clothing, shelter, cleanliness, or other material needs. Significant deprivation in these areas, particularly nutrition, in the first two years of life can lead to serious permanent deficits in general physical growth and brain development. Such deficits, even when mild, can diminish the adult's ability to cope with problems in an optimistic way. Material neglect may or may not have been present in the early lives of abusive and neglectful parents, and may or may not appear in their present dealings with their children. Abusive behavior is not always accompanied by material neglect.

Far more prevalent in the life history of the parents is the phenomenon of emotional neglect—the lack of warm, sensitive interaction that is necessary for the child's optimal growth and development. Rather than being empathically aware of and responding appropriately to the child's state and needs, the parent disregards the child's condition and is oriented primarily toward his or her own needs and convenience. Lack of adequate empathic care or "mothering" during the first two years of life has profound and enduring effects. Most evident are a deep lack of basic trust and confidence, and a tragically low sense of self-esteem that persists into adulthood.

The ability to be an empathic caretaker of a child is directly related to the degree of empathic care the parent received in his or her own first months. In this phenomenon of infantile experience as the basic determinant of later adult behavior, we see the essence of the cyclic nature of abusive child-rearing patterns. Abusive behavior can be transmitted from generation to generation. The infant who receives inadequate care can become an adult unable to care adequately for a child, unless new patterns are learned in the intervening years.

As children, most abusive parents were also expected to perform at higher than average levels for their age. Their caretakers demanded too much of them much too soon. Inevitably, they could not meet all the high standards of behavior set for them, and they were scolded, belittled, criticized as ineffective, and often physically punished for their failures. Physical punishment inflicted on children because they misbehave or otherwise fail to

satisfy their parents results in the bruises, lacerations, fractures, burns, and other injuries that characterize child abuse.

The triad of insufficient empathic love and care, premature and extreme demands for performance, and excessive criticism and physical punishment for failure constitutes the essence of the child abuse syndrome.

Psychological Characteristics of the Parents

There are certain personality factors and traits prominent in abusive and neglectful parents. These include a special form of immaturity and associated dependency; extremely low self-esteem and a sense of incompetence; difficulty in seeking pleasure and finding satisfaction in the adult world; social isolation and reluctance to seek help; significant misperceptions of the child; fear of spoiling children; a strong belief in the value of punishment; and serious lack of ability to be empathically aware of the child's condition and needs. The cumulative effect of this constellation of psychological characteristics makes it extremely difficult for the parent to succeed in meeting the demanding tasks of child care.

Immaturity and Dependence. Parents who maltreat their children are often described as being "immature," "needy," and "dependent." For many, perhaps most, of these parents, the descriptions are essentially accurate; yet too often they are used in a critical and derogatory sense rather than as valuable clues to the basic character difficulties that must be dealt with in treatment.

The parents' immaturity can best be understood as a phenomenon of developmental arrest or as a partial blockage of normal personality growth. As children, these parents were generally forced to disregard their own thoughts and feelings in favor of strict obedience to external demands. Inevitably, their maturation and development were inhibited. They have been unable to use their innate abilities to develop an independent, internal body of knowledge that would enable them to use good judgment about how to run their lives. To a large extent, they have remained "immature" and "helpless," needing proper authority to tell them what to do and when and how to do it. The "proper

authority" they typically rely on is the set of rules they remember from childhood.

Closely interwoven with the parents' immaturity is the ever-present problem of dependency. As already noted, children who are blocked in their attempts to develop inner directional controls become dependent on external authority for direction, evaluation, and reassurance concerning their successes and failures in the world.

One form of dependency present in almost all abusive and neglectful parents is manifested in their painful and usually ineffectual search for the love, affection, and interest which they need in order to become adequate and capable adults. Such dependency may be expressed openly and directly very early in a therapeutic relationship, or may be concealed for a long time and expressed only in indirect ways.

The parents' deep inner emptiness and their yearning need for satisfaction, care, and consideration are the persistent residue of an emotionally deprived childhood, directly related to a lack of adequate empathic mothering. As infants and small children, their care was not appropriate to their state, needs, or stage of development; instead, it was predominantly oriented towards the needs, convenience, whims, and demands of their caretakers, particularly their mothers. They have little, if any, experience of feeling safe, loved, comforted, listened to, and adequately cared for. Since adequate mothering in early childhood is a necessary component of healthy physical and emotional growth, it is again evident that the development of these parents has been blocked to some degree.

The immaturity and dependency described above are essentially functional in nature, related to emotional deprivation in early life. However, a small but significant number of parents exhibiting these traits suffered organic brain damage in their earliest years as a result of abuse or neglect. Due to either head trauma or malnutrition during critical growth periods, they had perceptual difficulties, delayed language development, and lowered IQ—deficits that can later produce a condition characterized by significant lack of basic knowledge and by attitudes of helplessness, immaturity, and dependency.

Sense of Personal Incompetence. One aspect of immaturity is the high need for reassurance many parents express. They lack adequate confidence in their knowledge of what is best to do, and need a great amount of feedback to reassure them that they have not made a mistake. Their childhoods were so filled with criticism and accusations of failure that they still cannot trust their own estimate of their performance. If there are no usable clues in the immediate environment to guide them to appropriate actions, the parents may quickly and automatically fall back on the patterns learned in childhood and repeat the behavior of their own parents.

This is particularly true in situations that appear to be a crisis or involve significant emotional tension. In general, abusive and neglectful parents have a significant inability to plan for the future. Problems are managed through short-term, *ad hoc* solutions that may resolve the immediate situation but have little positive bearing on long-term success. The handling of crises in this ineffectual way simply lays the groundwork for further crises.

These patterns of problem-solving are reminiscent of those used by children and adolescents, but they are not entirely age-related. Similar patterns of coping with life's problems are used by parents of various ages—from those in their late teens to those 30 or 40 years of age.

Difficulty in Experiencing Pleasure. Abusive and neglectful parents, as a group, can also be characterized by their diminished ability to experience pleasure. For many, the difficulty is serious. They cannot describe rewarding, pleasurable interaction with relatives or neighbors. Friendships are shallow, and their social activity is minimal and lacks significant meaning. Their marriages, either legal or common law, may be held together more by mutual neediness and insecurity than by real love and happiness. Even when stable and continuing, the marriage is often marred by poor communication, inconsideration, and lack of joy. The husband and wife seldom, if ever, even find the opportunity to go out for an evening together.

Among such parents, women in particular have difficulty obtaining genuine sexual pleasure with satisfying orgasm. Instead, sex is overshadowed by their general sense of needing to be

loved, cared for, petted, cuddled, and held in an almost child-like way. Although the men are orgastic, they are less oriented towards sensual pleasure than toward a need to bolster a fragile sense of masculinity and competence through sex.

Lack of pleasure can also be observed in the interaction between the parents and their children. The mothers and fathers show little joy in the simple fact of having children and rarely exhibit pride in the child's growth and accomplishments. They view their children's performance as an expected compliance to duty rather than as pleasurable discovery and admirable development. The parents' strict control inhibits the pleasurable, playful, and exploratory activities of the child. Pleasurable vocal and tactile interactions between parent and child are few.

Such pervasive incapacity for happiness begins in early childhood and persists into adulthood, leaving the parent vulnerable. With no adequately rewarding adult relationships and no way of satisfying personal needs, the parent inevitably turns to the child for satisfaction. The child has to make up for the deficiencies in the parent's life, is taxed far beyond his or her abilities, and inevitably fails. If the parent views such failure as a punishable offense, abuse can then occur.

Social Isolation. As noted above, one significant problem stemming from the deficit of adequate empathic mothering during infancy is a lack of basic trust and confidence. Most maltreating parents learned very early that they could not rely on others for appropriate sympathetic response. As a result, their interactions with relatives, neighbors, and friends are generally limited and unrewarding. They are isolated, often to an extreme degree.

It is not surprising that these parents are frequently described as being "resistant to help." During childhood, those to whom they looked for help generally either neglected or abused them. As parents, they are not only reluctant to seek help, they may actively avoid or refuse it. Despite superficial cooperative attitudes in some parents, they tend to view with suspicion those who offer them help.

Because of the parents' immaturity, excessive dependence, and failure to respond appropriately to offers of help, many workers conclude that the parents are "unmotivated" and "untreatable." Admittedly, these personality factors place abusive and neglectful parents among the more difficult treatment clients; yet in general, immaturity, dependence, and resistance to help are the very factors that must be treated in order for the parent to be helped. Awareness of the origin of these problems in the parents' early life makes their presence more understandable and gives the worker a rational basis for approaching treatment.

Upon entering a therapeutic relationship, not all abusive parents reveal the typical patterns of immaturity, dependency, and passive resistance. On the contrary, some are belligerent, antagonistic, very sure of themselves, and critical of everyone else; they may aggressively demand to be left alone. Despite this rather striking difference in outward behavior and attitudes, these parents are usually just as frightened, immature, and dependent as those who show no superficial aggression. Their angry, assertive self-confidence is at least in part a shaky defense to cover great neediness, loneliness, helplessness, and tragically low self-esteem. Their psuedo-independence and "leave me alone" attitude are basically expressions of their fear of being hurt or rejected once again. They too suffer from social isolation.

Misperceptions of the Child. As already noted, the parents' unrealistic expectations of performance from their children are oriented toward the parents' rather than the children's satisfaction and needs. This pattern of interaction involves the parents' significant misperception of the children and has often been called "role reversal," an apt and accurate description of the phenomenon. The parent is much like a helpless child looking to his or her own baby for parental care and comfort.

Several elements are involved in such role reversal. First, the residue of infantile deprivation persistently leads the parent to feel like a child looking for parental care to pacify his or her emptiness. Second, firmly rooted in the parent's childhood experience is the strong belief that parents automatically turn to their children for gratification of need. This belief gives a note of authority to the process. A third element of a different, almost

opposite, nature frequently expressed by parents is that the crying infant sounds "just like my mother (or father) screaming at me to do something and criticizing me for failing." The object that should be satisfying becomes instead an attacking figure; this explains in part the arousal of seemingly irrational anger in the parent.

Other common misperceptions are that the child is in some way innately evil, deficient, or destructive, and is deliberately trying to thwart the parent or make the parent's life miserable. These ideas are often related to the perception of the child as the embodiment of the parent's own "bad" childhood self or as having the characteristics of undesirable relatives. The child may be described as being "as bad as I was when I was a kid," "just like his no good father," or "as mean as my lousy sister."

Misperceptions may be expressed quite openly, but are more often essentially unconscious. Whether expressed or not, parental misperceptions have a profound effect on the instigation of abuse. They also have an understandable origin, despite their apparent irrationality.

The problem of misperceptions can be complicated by the presence of real abnormalities in the child. Because of prematurity, congenital defects, illness, genetically determined hyperactivity, or various other conditions, some babies are inevitably more demanding and less rewarding than others in their responses to their parents. Even normal babies can be seen as troublesome and unsatisfactory if they are born at an inconvenient time, are of an unwanted sex, or are otherwise undesirable. Such reality factors, however, should not be confused with the basic tendency of the parents to misperceive the child and to cloak their misperceptions under the guise of reality. The parents' general immaturity and dependency lead them in a childlike fashion to see all their difficulties as the fault of outside forces.

Fear of "Spoiling" Children. The abusive or neglectful parent generally believes that babies should not be "given in to" nor allowed to "get away with anything", that they should not be picked up and comforted when they cry nor be permitted to become too dependent, and that they must periodically be shown

"who's boss" and made to respect authority so they will not become sassy or stubborn. The fear of spoiling children and the measures taken to avoid it are common in a moderate form throughout Western culture, but are often expressed in an extreme degree in the abusive parent-child relationship.

Belief in the Value of Punishment. The punitive parental attack is not a haphazard, impulsive, and uncontrolled discharge of aggression onto the child. On the contrary, it appears to be a specifically organized unit of behavior designed to punish and correct specific bad conduct or inadequacy in the child.

The problem lies in the parents' unrealistic estimates of the child's abilities and in their misperceptions of the child. The parents see the infant as more mature than he or she really is, and expect the child to be able to satisfy their wishes. The child's failure to do so implies stubbornness or purposeful meanness, behavior that the parents have the moral right and duty to correct. Much of what the parents find wrong in their offspring are the very things for which they were criticized and punished as children. Punishment therefore carries the approval of traditional family authority and an aura of righteousness.

This view of parental aggression—that it is a specifically structured action—is supported by two frequent observations: often only one child in a family is abused, while the others are not; and the child is punished only for certain misbehaviors and not for others. In addition, psychological testing indicates that free impulsivity is not a common characteristic of abusive parents. The parents do not discharge aggression indiscriminately, even though when they are under stress aggression may be rather suddenly and explosively released.

Together with our cultural disapproval of dependency and the accompanying fear of "spoiling" children, there is in Western culture a pervasive belief in the educational value of punishment. The close relation between these attitudes is nicely expressed in the saying "spare the rod and spoil the child," a belief still held by many people, either openly or subconsciously. Throughout history, people have held that punishment will deter bad behavior and instigate more acceptable performance. There is no

question about the former: it can be demonstrated in lower animals as well as in man that physical punishment will quickly inhibit behaviors toward which it is directed. However, the usefulness of punishment to produce good behavior has never been adequately documented. Some evidence indicates that, over the long term, punishment is not effective in stopping undesirable behaviors nor in creating those desired. In fact, punishment may ultimately perpetuate undesirable patterns of behavior.

Unawareness of the Child's Needs. It is doubtful that the release of aggression which results in physical abuse could occur if the parents were able to be empathically aware of the child's needs. The parents' lack of awareness is a direct product of their lack of empathic loving care during childhood. Experience indicates that abusive parents cannot easily change their own patterns of child care unless they receive some of the care and consideration which was denied them in childhood but which is still necessary for their growth.

The Role of Crises

The daily care of infants and small children requires large amounts of time and physical energy, in addition to much patience, ingenuity, and empathic understanding and response—characteristics that, in general, are tragically lacking in abusive and neglectful parents. Their needs have never been satisfied well enough to provide the surplus in emotional resources needed for adequate child care. With good reason, the parents often doubt their own ability to do even a minimally acceptable job; yet they do not know where or how to seek help. They lack the support of a spouse, family, and friends and, probably most important, are unable to get pleasure out of life and to trust other people. Having no storehouse of spare emotional energy, they live a precarious hand-to-mouth emotional life, without the hope or the supportive contacts to tide them over periods of crisis. For these reasons, crises play a crucial role in their lives and are often the precipitators of incidents of abuse.

As all parents know, crises are a fact of life. Crises can involve finances, housing, jobs, family relationships, illness, the death of a relative, the breakdown of the car or television, separation from close friends, or any number of other occurrences and

things. Since abusive parents typically lack the self-confidence, ingenuity, and ability to seek help necessary to cope with crises, any crisis has a greater impact on them than on someone with better coping abilities.

An inadequately managed crisis will persist longer, become more distressing, and often develop into even more serious crises. The situation may eventually become unmanageable: the parent is pushed beyond his or her strength, feels desperately helpless, and ends up abusing the child. Any crisis—whether a major one such as job loss, a less serious one such as the breakdown of a washing machine, or an emotionally significant one such as the spouse's failure to remember a birthday—may be the last straw needed to push the parent into feeling overwhelmed.

Chapter 3
Case Management*

Punishment vs. Treatment

Fragmented perceptions of child abuse and neglect have produced contradictory views on case management. In general, there are two ways of approaching the problem. The punitive approach follows from the view of maltreatment as a crime for which parents must be punished; the therapeutic approach, from the view of a family problem requiring treatment. This punishment vs. treatment dichotomy can even be found in the law. In all 50 states, laws pertaining to child abuse and neglect fall under both the criminal and the civil codes.

The maltreatment of children is a crime in every state. More than three-fourths of the states have specific "cruelty to children" statutes; in the others, the crime of "assault," under either statutory or common law, applies to child abuse. The cruelty to children statutes usually cover a much broader area than assault; some include, for example, neglect and emotional maltreatment. In addition, sexual abuse can be prosecuted under criminal statutes covering statutory rape, incest, indecent liberties, and other sexual crimes.

Within the civil code of every state, child maltreatment is covered under juvenile court acts which authorize the court

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to order protective supervision, treatment, or removal of a child when there is evidence of abuse or neglect. Every state also has legislation that either explicitly or implicitly provides for protective services for maltreated children as part of a public child welfare program.

In addition, all 50 states, the District of Columbia, the Virgin Islands, and Guam have mandatory reporting laws that require designated persons to report suspected cases of child maltreatment. As Table 1 shows, reporting statutes are housed in the criminal codes of 14 states and Guam, and in the civil codes of 37 states, the District of Columbia, and the Virgin Islands. (In Arizona, there are two separate reporting statutes—one under the criminal code, one under the civil code.)

Seen from an historical, nationwide perspective, the approach to child protection has gradually been shifting from punitive to therapeutic. Organized efforts to protect abused and neglected children were first made late in the nineteenth century. Over the years, child protective agencies have been established under both public and private auspices. The initial concept of protection stressed the "rescue" of children and the prosecution of "offending" parents. This has slowly but steadily given way to the proposition that treatment and rehabilitation, rather than punishment and retribution, are the best means of protecting endangered children. There is a growing commitment throughout the country to the provision of rehabilitative and supportive services to families in which abuse or neglect occurs. If court action is necessary, the case is generally referred to the juvenile or family court. Criminal court involvement is relatively infrequent.

However, the general concept of child maltreatment has by no means been decriminalized. State reporting laws, for example, frequently specify police handling of reports. Compared to 17 statutes that assign prime investigative responsibility to child protective agencies, more than 25 give the option of having the police or protective services investigate; five specify a police investigation alone; and several provide for a joint investigation by the police and the protective service agency.

Except in severe or notorious cases, however, police involvement is rare. (California is a noteworthy exception to this general

statement.) In nearly all communities, even where the reporting law specifies a police investigation, most reports are referred to protective service agencies for investigation and provision of services. If the police receive the original report, they typically forward it to protective services or to the juvenile court. In some cases, the police may perform a parallel or joint investigation with the agency. Police involvement is almost always through the department's youth bureau, juvenile division, or an individual officer specializing in youth or family matters.

There are several advantages in having social workers rather than police investigate reports of maltreatment. Although any investigator may face noncooperation and even hostility from the parents, the social worker is more likely to be seen as a helping person, or at least as less of a threat than the police officer. The protective service worker is (or should be) trained to evaluate the parents and the home to determine the risk to the child and the family's need for services. Such psycho-social evaluations are generally outside the professional competence of the police. In addition, the police cannot offer rehabilitation and supportive services to families, whereas protective service workers can provide these either directly or through referral. The police can take the child into protective custody and can make a criminal charge against the parents, but can do little to protect the long-term interests of children and families.

The feasibility and usefulness of criminal prosecution is quite limited. In short, it is extremely difficult to prove in criminal court that a parent is guilty of child maltreatment. Abuse and neglect take place in the home; without witnesses, only circumstantial evidence is ordinarily available. The burden of proof "beyond a reasonable doubt" and other constitutional strictures often pose insurmountable obstacles to successful criminal prosecution.

Criminal prosecution is likely to do more harm than good for the family. The criminal court process may embitter the parents, making them resent their children even more and reinforcing their lack of trust in people, particularly in authority figures. When parents are acquitted, they may regard the acquittal as approval of their parenting behavior. When they are convicted, their behavior is seldom altered by a prison term or a suspended sentence. Criminal prosecution rarely results in rehabilitative

treatment for the parents' underlying problems. Nothing prevents them from continuing to maltreat their children or bearing other children whom they may abuse or neglect. Rehabilitative work, at this point, becomes more difficult if not impossible.

Fear of criminal prosecution may also deter parents from taking an injured child for medical care. On the other hand, there is evidence that the availability of well-publicized therapeutic programs—such as Parents Anonymous groups, crisis-intervention hotlines, and other treatment modalities discussed in Volume 3—can induce parents to refer themselves for help.

To regard child maltreatment as a crime for which parents must be punished is to deny that maltreatment is a parents' problem. And as Jolly K., the founder of Parents Anonymous and herself a former abusive parent, explains: "To deny that the child abuser has a problem is to deny services to that person." [1] The slow, cumbersome, and punitive procedures of the criminal courts are incapable of dealing effectively with the problem of abuse and neglect.

The Child Protective System

By the early 1970s, elaborate but generally fragmented systems of child protection had developed in all states. Despite variations by particular state and community, the following elements are included: a mandatory reporting process; public and private child protective services; and various other agencies and individuals involved in the identification, disposition, or treatment of cases. This complex of laws, agencies, and people usually resembles more a patchwork of divergent philosophies and procedures than a coordinated and well-functioning system.

Reporting. When adults are attacked or otherwise wronged, they can go to the police or the courts for protection and redress of their grievance. The child victims of abuse and neglect, however, are usually too young or too frightened to seek help on their own. Unless the parents seek and obtain help with the problem, protection for the child is possible only when some third person—a friend, a neighbor, a relative, or a professional who sees the child—recognizes the family's problem and brings it to the attention of the proper authorities. If no one reports the

situation, no one can protect the child, and no one can help the parents.

The identification of families having the problem of abuse and neglect is haphazard in most communities. The case of Robin M., cited in the report of the New York State Assembly Select-Committee on Child Abuse, illustrates a nationwide pattern.

> *In early 1971, Robin, a 43-day-old infant, was brought by her mother to a hospital; she was in a coma and had multiple fractures. She died shortly afterward. The coroner's report listed the causes of death as extensive multiple skull fractures, sub-arachnoid hemorrhage, and contusion of the brain. The mother claimed that Robin had fallen out of bed.*
>
> *Prior to the child's death, the family had had frequent contact with the hospital. In the preceding month, Robin's two-year-old brother had been seen three times by the hospital's pediatric clinic. At the last clinic examination, two weeks before Robin's death, the hospital record states that the boy was found to have "stick marks over the left shoulder." No report of this finding was made until after Robin had died.*

Many children continue to suffer injury and some die without being recognized by or reported to protective agencies. The various professional groups mandated by law to report often fail to do so because they are unfamiliar with the nature of abuse and neglect or with their reporting responsibilities. The public seldom has a clear understanding of the seriousness of the problem and the importance of identification.

It often takes a tragedy in the community—a child's death or serious injury followed by sensational press coverage—to stimulate the reporting of other children. Even then, people tend to report only the more serious cases. There are various reasons for under-reporting. Professionals as well as laypeople are often unaware of the signs and symptoms of abuse and neglect. Many hospitals lack adequate diagnostic capabilities. People are sometimes reluctant to subject parents to prosecution or the removal of their children, or to become involved in court proceedings themselves. Professionals in private practice may hesitate to report their clients; others may hesitate to report their relatives, neighbors, or friends. In many communities, the system of child protection itself mitigates against reporting: when the reporting

process is allowed to remain haphazard, when neither reported children nor their parents are given appropriate help and treatment, people are often reluctant to report.

The concept of mandatory reporting of suspected child maltreatment is relatively recent. Prior to 1964, there were no child abuse reporting laws as we know them today; yet after the U.S. Children's Bureau proposed a model reporting law in 1963, all 50 states enacted such legislation within five years. Abuse reporting laws are the most tinkered with, the most revised of all statutes. Every year, 10 to 15 states amend their reporting legislation.

Reportable Conditions. Reporting laws vary greatly in specifying the circumstances or conditions that designated persons must report. The early reporting laws, based on the Children's Bureau model, generally required the reporting of "nonaccidental injuries," and sometimes added the broader phrase "or other serious abuse or maltreatment."

Even before passage of the 1973 federal Child Abuse Prevention and Treatment Act, Public Law 93–247—which includes physical, sexual, and mental maltreatment in its definition of abuse and neglect—state legislatures were broadening the conditions that require a report. More and more states are agreeing that physical abuse and battering, sexual abuse, physical neglect, and emotional maltreatment are all aspects of the same problem: the inadequate parental care of children. In 38 states, the District of Columbia, and Guam, injuries resulting from neglect are expressly included as reportable conditions.[2] Sexual abuse is included in 13 reporting laws; malnutrition in four; excessive corporal punishment in one; disfigurement in two; and "tortured, cruelly confined, or cruelly punished" in two. Several states also require the reporting of conditions detrimental to a child's "moral or emotional well-being." The maximum age for coverage varies between 12 and 18 (see Table 1).

The amount of coverage the reporting law provides determines in part the adequacy of the state's reporting process. For example, if child neglect is not covered by the reporting law, the person faced with an apparently maltreated child is forced to determine whether abuse or neglect was involved. If the child is suspected

Table 1

Some Basic Elements of Reporting Laws*

State	Amended	Maximum Age for Coverage	Part of Criminal Code	Penalty for Not Reporting Included	Definition of Abuse or Neglect Included
Alabama	1969	16		X	
Alaska	1971	16			X
Arizona					
Penal Statute	1972	16	X	X	
Civil Statute	1972	18			X
Arkansas	1967	16	X	X	
California	1973	12	X		
Colorado	1972	18			X
Connecticut	1973	18		X	
Delaware	1971	18 [1]		X	
D. of C.	1966	18			
Florida	1971	17	X	X	X
Georgia	1973	18			
Hawaii	1970	minor			
Idaho	1973	18			X
Illinois	1973	child			
Indiana	1971	child		X	
Iowa	1965	18			
Kansas	1972	18	X	X	X
Kentucky	1972	18			
Louisiana	1972	17	X	X	X
Maine	1965	16		X	
Maryland	1973	18	X		X
Massachusetts	1973	16			
Michigan	1970	17	X	X	
Minnesota	1965	minor	X	X	
Mississippi	1973	18			X
Missouri	1969	17		X	
Montana	1973	minor			
Nebraska	1973	minor [2]	X	X	X
Nevada	1973	18	X	X	
New Hampshire	1971	18		X	X
New Jersey	1973	18		X [3]	X [3]
New Mexico	1973	18		X	X

Continued on next page

State	Amended	Maximum Age for Coverage	Part of Criminal Code	Penalty for Not Reporting Included	Definition of Abuse or Neglect Included
New York	1973	18 [4]		X	X
North Carolina	1973	16			X
North Dakota	1965	18			
Ohio	1969	18 [5]			
Oklahoma	1972	18	X	X	
Oregon	1971	15			X
Pennsylvania	1970	18		X	
Rhode Island	1971	18			X
South Carolina	1972	17		X	
South Dakota	1973	18	X	X	
Tennessee	1973	18		X	
Texas	1973	child			
Utah	1965	minor		X	
Vermont	1965	16	X	X	
Virginia	1973	16			
Washington	1972	18 [1]		X	
West Virginia	1970	18			
Wisconsin	1967	child		X	
Wyoming	1971	18		X	X
Guam	1967	18	X	X	
Virgin Islands	1970	15		X	

1. Coverage is extended to the menetally retarded, regardless of age.
2. Coverage is extended to any "incompetent or disabled person."
3. Like Arizona, New Jersey has two reporting statutes; both are under the civil code. The one applicable to the medical profession includes no definition of abuse; that applicable to "any person" does define abuse, abandonment, cruelty, and neglect. The penalty for nonreporting differs between the two statutes.
4. Under age 16 for an "abused" child; under age 18 for a "maltreated" child.
5. In the case of a crippled or otherwise handicapped child, coverage extends to age 21.

*Adapted from De Francis and Lucht, *Child Abuse Legislation in the 1970's*, Table I, pp. 18–19.

of having been neglected rather than abused, it is possible that the case will not be reported.

Distinctions between abuse and neglect should have no place in decisions of whether to report a case of maltreatment; nor should they have a place in decisions of whether or how society should intervene to protect a child. To single out one form of maltreatment for particular attention is to establish false

and dangerously misleading distinctions. Neglect can be as damaging and as deadly as abuse.

Mandated Reporters. The medical profession was the first and remains the foremost target of reporting statutes. Doctors are the professionals most likely to have contact with injured children, and are presumed able to recognize the signs of abuse and neglect. The initial focus on physicians was soon expanded to include other professionals in the "healing arts": hospitals, dentists, nurses, surgeons, osteopaths, and chiropractors. Some states also specifically require pharmacists, optometrists, podiatrists, and religious healers to report.

Most legislatures have added to their list of mandated reporters various other professionals who regularly come in contact with children: teachers and other school personnel, social workers, psychologists, the personnel of child-caring institutions, police officers, clergymen, and attorneys. In addition to these and several other groups of professionals mandated to report, 23 states require reporting by "any person," and seven state laws specifically note that anyone may report.

While fewer than half the state reporting laws require private citizens to report, this group is the source of more than 75 percent of all reports of abuse and neglect nationwide. However, reports from nonmandated sources often have a second-class status: they are frequently given lower investigative priority, are not recorded in the central register of reports in some states, and are sometimes excluded from published statistics of abuse and neglect. In part, such discrimination between reporting sources stems from a desire to follow apparent legislative mandate; but more often it is due to the need to assign investigative priorities because of scarce resources. Whatever the reasons behind such practices, the consequences can be tragic.

For example, in many states the police are not included as mandated reporters. If the police learn of a child who is abused or neglected, their nonmandated report may not be accepted by the state's central register. Unless the child is seen by a mandated source who makes a report, the case may never be listed in the register nor investigated by the child protective agency. The following case, which was included in the report of

Table 2
Specified Reporters*

State	Physician	Surgeon	Osteopath	Dentist	Resident	Intern	Hospital/Institution	Practitioner/Arts	Chiropractor	Pharmacists	Nurses	Teachers	Other School Personnel	Social Workers	Law Enforcement	Coroner/Medical Examiner	Psychologists	Optometrists	Podiatrists	Religious Healers	Child-Caring Institutions	Clergymen	Attorneys	Any Other Person	Miscellaneous
Alabama	X	X					X			X	X	X		X										X[1]	
Alaska	X	X	X	X			X	X	X		X	X		X	X		X	X	X						X
Arizona	X				X	X	X																	X	
Arkansas	X		X	X	X	X	X		X	X	X					X								X[2]	X
California	X	X		X	X	X			X		X	X	X	X					X	X	X				
Colorado	X						X				X		X	X										X	
Connecticut	X	X		X	X	X	X				X	X	X	X	X	X	X					X		X	
Delaware	X		X	X	X	X		X			X		X	X		X	X							X	
D. of C.	X						X																		
Florida	X			X	X	X	X				X	X		X				X	X		X				
Georgia	X		X	X	X	X	X				X		X	X					X		X[3]			X	
Hawaii	X		X	X			X	X			X	X		X		X								X[4]	
Idaho	X				X	X					X	X		X		X					X			X	
Illinois	X	X	X	X					X		X	X	X	X	X				X	X	X				X
Indiana																								X	
Iowa	X	X	X	X	X	X	X		X		X							X	X					X[4]	
Kansas	X	X	X	X	X	X	X		X		X	X	X	X	X		X								
Kentucky	X		X				X				X	X	X	X		X								X	
Louisiana	X				X	X	X				X	X		X							X			X	
Maine	X		X		X	X	X		X																
Maryland	X	X		X	X	X		X			X	X	X	X	X		X							X	X
Massachusetts	X			X		X					X	X	X	X	X	X								X[4]	X
Michigan	X						X				X		X	X	X										
Minnesota	X	X					X	X		X	X														
Mississippi	X			X	X	X	X				X														
Missouri	X	X		X			X		X		X	X		X					X	X	X				
Montana	X										X	X		X	X								X	X	
Nebraska	X						X				X		X	X										X	
Nevada	X	X	X	X	X	X	X		X		X	X	X	X				X			X	X	X		

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State	Physician	Surgeon	Osteopath	Dentist	Resident	Intern	Hospital/Institution	Practitioner/Arts	Chiropractor	Pharmacists	Nurses	Teachers	Other School Personnel	Law Enforcement	Social Workers	Coroner/Medical Examiner	Psychologists	Optometrists	Podiatrists	Religious Healers	Child-Caring Institutions	Clergymen	Attorneys	Any Other Person	Miscellaneous
New Hampshire							X																	X	
New Jersey	X		X		X	X	X																	X	
New Mexico	X				X	X					X	X		X	X									X	
New York	X	X	X	X	X	X	X		X		X		X	X	X	X		X	X	X	X			X[2]	X
North Carolina	X	X	X	X	X	X	X		X		X	X	X	X	X	X		X	X	X				X	X
North Dakota	X		X		X	X			X		X														
Ohio	X	X		X	X	X	X				X	X	X	X					X	X					
Oklahoma	X	X	X	X	X	X					X													X	
Oregon	X			X		X					X	X	X	X	X										
Pennsylvania	X		X		X	X	X				X	X												X[2]	
Rhode Island	X		X		X	X	X																		
South Carolina								X																X	
South Dakota	X	X	X	X	X	X	X		X					X	X		X	X	X					X[2]	
Tennessee							X																	X	
Texas																								X	
Utah							X																	X	
Vermont	X		X		X	X	X		X																
Virginia	X				X	X	X	X			X	X		X	X						X				
Washington	X	X	X	X			X		X	X	X	X	X	X			X		X	X		X			X
West Virginia	X	X			X	X	X	X			X	X		X											
Wisconsin	X	X		X			X				X		X	X											
Wyoming	X	X	X	X	X	X	X		X	X	X	X	X	X					X					X	X
Guam	X	X		X			X				X														
Virgin Islands	X						X				X														

1. "... any other person called upon to render aid or medical assistance."
2. Any other person *may* report.
3. "... or other person charged with the responsibility for the health, welfare, or education of a child."

*De Francis and Lucht, *Child Abuse Legislation in the 1970's*, Table II, pp. 22-23.

the New York State Assembly Select Committee on Child Abuse, illustrates the possible consequences of this policy.

> *In October 1972, 10½-year-old Denise was found strangled to death in the room of a neighborhood male drifter; she had been lured there from a candy store with the promise of food. Denise had often been seen at 3 or 4 a.m. asking for food on the street where she lived with her mother and five younger brothers and sisters. Frequently, when left unfed and alone, she and her 8-year-old sister Odell went to the neighbors for food at midnight or later. The superintendent of the building had called the local police a number of times, but they never responded to the calls. The neighborhood school had tried to help the children until the family had moved. In their new neighborhood, neither Denise nor her two school-aged sisters were registered for school. Their mother had been receiving Aid to Dependent Children continuously since 1961—aid that obviously did not go to the children. It was only after the police went to the home to investigate Denise's death that a neglect petition was filed.*

If the police had been required to report, perhaps the first call for assistance in this case would not have gone unanswered. But it should be noted that the school was a mandated source that failed to report Denise's case.

Some states are expanding the mandate to report to large numbers of people. Theoretically, increases in the number of mandated reporters will increase the number of reports. But as Dean Paulsen cautions, overgeneralizing the class of people legally required to report could prove to be a problem itself: "If the reporting group as delineated by statute is large, the impact of the reporting requirement may be diffused, and everybody's duty may become nobody's duty."[3] The wisdom of what would amount to an unenforceable and therefore empty statutory mandate is questionable.

A generally preferable approach is to allow anyone to report but to require reports from specific, identifiable professions or groups that would be responsive to such targeting. Obviously, the source of a report should not be used as a criterion to differentiate case handling. In addition, immunity from civil and criminal liability should be granted to nonmandated as well as

mandated sources who report in good faith. Immunity is indispensible to the working of the reporting law; it removes the fear of an unjust lawsuit for attempts to help protect a child via a report.

To fulfill their legal obligations and exercise their reporting powers, both mandated reporters and private citizens must be able to understand their state's reporting law. Ignorance and misunderstanding of the law and child protective procedures in general are probably the main causes of under-reporting. Numerous amendments, grafting new mandated sources and reporting procedures onto existing statutes, have made most reporting laws confusing to lawyer and layman alike. This confusion seriously limits reporting. A first priority in most states should be a simple redrafting of the reporting statute to clarify its meaning and readability and to simplify the reporting process.

Receipt of Reports. The agency specified by law to receive reports bears the prime responsibility for protecting children in the state. In more than half the states, however, no single agency is designated. The fragmented reporting process in most communities mirrors the fragmentation of basic child protective responsibility.

Only 23 reporting laws specify a single agency to receive all reports. Of these laws, 17 require reporting to a child protective agency, five to a law enforcement agency, and one to the juvenile court. Nearly half the states allow mandated reporters to choose between two specified agencies; six require reporting to one of three or more agencies; and several states require reports to go to two or more designated agencies.

The recent phenomenon of "two-tier" reporting further complicates the reporting process. In states such as Connecticut, Florida, Idaho, and New York, which have statewide registers, reports are encouraged to go directly to the register; nevertheless, many continue to be made to the local child protective agency or the police. These agencies must then report to the register. The purpose of centralized statewide reporting is to ensure the efficient handling of reports and to permit state monitoring of cases. The continuation of two-tier reporting seems inconsistent with these objectives.

Table 3
Receipt of Reports*

State	County Department of Social Services	State Department of Social Services	Juvenile or Family Court	Agency Authorized by the Court	District Attorney	Police	Sheriff	State Police
Alabama	X				X[1]	X	X	
Alaska		X				X	X	
Arizona		X				X	X	
Arkansas	X	X				X	X	
California			X			X	X	
Colorado						X	X	
Connecticut		X				X		X
Delaware		X				X	X	
D. of C.						X		
Florida		X						
Georgia	X[2]							
Hawaii		X						
Idaho					X	X	X	X
Illinois		X				X	X	
Indiana	X					X	X	
Iowa	X				X	X	X	
Kansas	X		X					
Kentucky		X						
Louisiana	X					X	X	X
Maine		X			X			
Maryland	X				X	X	X	
Massachusetts		X						
Michigan	X	X	X		X			
Minnesota	X					X	X	
Mississippi	X			X				
Missouri	X		X			X	X	
Montana	X	X						
Nebraska						X	X	
Nevada	X			X		X	X	
New Hampshire		X						

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State	County Department of Social Services	State Department of Social Services	Juvenile or Family Court	Agency Authorized by the Court	District Attorney	Police	Sheriff	State Police
New Jersey		X			X			
New Mexico	X		X					
New York	X[3]	X[3]						
North Carolina	X							
North Dakota	X		X		X			
Ohio						X	X	
Oklahoma	X							
Oregon			X			X	X	X
Pennsylvania	X							
Rhode Island		X				X	X	
South Carolina	X						X	
South Dakota			X					
Tennessee	X		X			X	X	
Texas	X					X	X	X
Utah		X				X	X[2]	
Vermont		X						
Virginia			X			X	X	
Washington					X	X	X	
West Virginia	X				X			
Wisconsin	X					X	X	
Wyoming	X							
Guam						X[4]		
Virgin Islands						X	X	

1. In Madison County only.
2. In the absence of a protective service agency, to an appropriate police authority.
3. Oral reports are to be made to the state central register, except where specified to go first to the local child protective service. Written reports are to be made to the appropriate local child protective service.
4. To the Department of Public Safety.

*De Francis and Lucht, *Child Abuse Legislation in the 1970's*, Table IIA, pp. 24–25.

The agency to which an individual reports depends on such diverse factors as the reporter's view of the need for criminal prosecution, his or her knowledge of the reporting process, the state's legislative framework, the quality of the community's child protective network, and chance factors such as the time of day the report is made. Out of ignorance, self-interest, or inertia, many people report to the agency they trust or know best. In some communities, in fact, there is such strong and broad consensus on how to handle case management that the explicit provisions of the reporting law are simply ignored.

In one state, through a turn of events that neither the police nor child protective workers can explain, the proposed 1973 reporting law was amended just before passage to require reporting solely to the police. No one, including the police, seems to approve of this last-minute change, and no one seems to follow it. When they do receive a report, the police immediately refer it to protective services. The state protective service agency has even published a brochure stating that reports must be made to protective services.

Child Protective Services (CPS). The 1967 report of a nationwide survey of child protective services defines CPS, an identifiable and specialized area of child welfare, as follows: "It is a program which seeks to prevent neglect, abuse and exploitation of children by reaching out with social services to stabilize family life. It seeks to preserve the family unit by strengthening parental capacity and ability to provide good child care. Its special attention is focused on families where unresolved problems have produced visible signs of neglect or abuse and the home situation presents actual and potentially greater hazard to the physical or emotional well-being of children."[4]

Generally located in public departments of social services, administered by either the county or the state, protective service programs tend to have three prime functions: to receive and investigate reports of abuse and neglect, to evaluate reported families, and to provide necessary services either directly or through referral.

Child protective agencies follow a fairly standard procedure in handling reports. There is an initial intake process that involves

limited screening, referral, and case assignment within the agency. The intake worker tries to obtain information concerning the suspected maltreatment in as clear, concise, and concrete a form as possible. The worker may contact schools, neighbors, relatives, and police to obtain information about the family and will often check for prior reports involving the parents, child, or siblings.

Although, theoretically, protective service workers are supervised by and accountable to an administrative bureaucracy, they have wide decision-making latitude. Their decisions usually become those of the agency. Often, their decisions can influence the life or death of children.

During the intake process, the worker may decide that no further action can be taken; the report may not meet the agency's criteria for abuse or neglect, or it may not present sufficient information to be investigated—such as a report that does not identify the name and address of the family. Various other decisions must be made by the intake worker: Is the report appropriate for CPS to handle, or should it be referred to another agency? If accepted, does the report require emergency action, or can it be handled more routinely? These decisions are difficult, and the answers often uncertain, particularly since there is usually only limited information at hand.

Reports accepted by CPS are assigned to protective caseworkers, responsible for investigation of the home and provision of services when appropriate. For the caseworker, decision making involves two simultaneously explored issues:

- verification of the report—Do the allegations appear valid? Are the child and family in need of protective services?
- determination of the family's needs—Is there a need for immediate action? Should the child be placed in protective custody? What kinds of rehabilitative or support services are necessary? Are such services available? Must the child be placed in foster care or permanently removed from the home? Is court involvement necessary?

Because the child protective process is interwined with critical decision making, the attitude and ability of the individual worker

are generally the most important factors in case management. The need to make hard decisions in order to investigate and verify third-person reports and to offer or impose treatment services sets child protective casework apart from most other types of social casework. Protective workers need a staggering combination of skills in order to be effective. Placed in the contradictory position of having to investigate a family while, at the same time, trying to establish a treatment relationship, they must be both policemen and social workers, investigators and friends. Protective services often suffer when workers cannot resolve these basic role ambivalences.

To be effective, protective workers need specialization and experience. Most, however, do not meet this ideal. In many communities, the public welfare department responsible for child protective services does not have a specialized protective service program. Caseworkers trained and experienced in the field of protective services may handle all types of child welfare cases, while cases of maltreatment are shared with relatively inexperienced staff.

Rapid turnover among the protective service staff compounds the problem; in some agencies, the rate exceeds 50 percent a year. Workers facing emotionally demanding work, with little training and inadequate backup, leave when they can no longer bear a job that offers little emotional satisfaction. Often, their prior experience and motivation are inconsistent with the necessary child protective skills. Those with Master of Social Work degrees quickly qualify for promotion to supervisory positions or find outside employment.

Frequent staff turnover creates a constant, critical need to train new and inexperienced workers. However, most local departments, even those with specialized protective staffs, either do not appreciate the need for training or lack the resources needed to mount a suitable training program. In addition, social work supervision, the mainstay of in-service training and education in social casework, is largely absent because of the administrative structure of the protective service unit or because the supervisors themselves lack sufficient training and skills. As a result, many protective workers have little training in protective services beyond a hasty orientation session. With little to guide them, they

must learn by trial and error in situations where a mistake can mean a child's life.

The caseworker's job is further complicated by parents who are usually unwilling or unmotivated clients in an involuntary process. Frequently, the parents view the worker as an intruder into their lives. To be an effective source of help, the worker must establish a relationship of trust with the family. Yet, because the worker is also responsible for investigating the family, the parents have reason to see his or her presence as a threat. In this light, hostility or silence is an understandable response from the parents; and role ambivalence is an understandable feeling in the worker.

The use of social workers to verify reports as well as to provide services presupposes their ability to perform competent investigations. Due to lack of adequate training in investigative techniques or to simple lack of talent for performing protective investigations, CPS workers often have great difficulty obtaining genuinely useful information about families. More than one-third of the protective workers interviewed in one survey honestly admitted their difficulty in verifying reports of abuse and neglect.[5]

Verification of a report generally means that, based on certain signs and indicators—including the physical condition of the child and the home, and the worker's evaluation of the psychosocial dynamics in the family—a professional opinion can be formed of whether or not the report is valid. It is almost always difficult to verify, to a certitude, reports of child maltreatment. Often, it is impossible. No matter how thorough the investigation, sometimes there is simply no clear evidence of what happened to the child. Unless a family member is willing and able to explain, there are seldom witnesses to step forward. Even a medical report describing concrete physical injuries suggestive of child battering is not alone sufficient for the caseworker, let alone a judge, to determine whether the child was in fact abused by the parents. Without a strong foundation of facts gained through the investigation, the caseworker cannot make important and necessary decisions with any real degree of confidence.

Dr. C. Henry Kempe concludes that, because of the role ambivalence inherent in the child protective process, "it would seem reasonable . . . to try to establish a clear separation of the investigative and therapeutic functions of caseworkers in the field of protective services." [6] In some counties and states, such a distinction has been made: "protective services" handles investigations and the provision of short-term services; "preventive services," the provision of long-term services. However, the separation of staff functions is often based on a perceived need to investigate cases quickly; staff resources are funneled into protective services, while effective long-term services are limited and overburdened.

Although generalizations are always tenuous, it is probably fair to say that most child protective agencies are unable to respond both programatically and administratively to the needs of the families they serve. Part of the cause is rigid bureaucracy as well as our inadequate understanding of how to influence human behavior. But a more specific cause lies in the fragmented and uncoordinated planning and policy making for child protective services. Public departments of social services, the primary location of CPS programs, are preoccupied with the problems of welfare administration and public assistance planning. The few staff interested in upgrading protective services are overwhelmed by other responsibilities of their departments and constrained by limited budgets and staff. They cannot give comprehensive direction and cannot assign priorities for the investment of scarce protective resources. (Volume 3, Chapter 2 includes a discussion of the use of the central register in improving program planning and development for CPS.)

Part of the solution to the problems of protective services includes the recruiting of sufficient numbers of qualified staff, the development of ongoing staff training, and the availability of multidisciplinary consultation to aid protective workers in evaluating families and determining their needs. (See Volume 2, Chapter 3 for a discussion of the role of the multidisciplinary consultation team.) But other, more immediate steps can be taken to help protective workers.

At present, most statutes governing child protective services provide only a general statement of purpose and philosophy.

They often refer to "stabilizing the family whenever possible," authorizing CPS to use the services of voluntary agencies, the police, and the courts when necessary. Clear and realistic goals must be set for those responsible for child protective services. To make the home "safe for the child's return" is an admirable statement of intent, but it contains no guidelines upon which child protective workers' decisions can be based. Although primarily an administrative concern, the need to establish criteria for decision making can benefit from legislative attention. The recently enacted New York law is instructive because of its detailed statutory description of the child protective process.

The New York reporting law is unique not only because of its explicit statement of child protective responsibilities—including evaluation of the home and determination of the risk to other children in the family—but also because of its requirement for extensive follow-up reports to the state's central register. Based on these reports, administrators of the register seek to guide and monitor the efforts of individual workers. The law requires protective workers to determine, within 90 days, whether a report is "indicated" or "unfounded," which prevents them from avoiding the hard decisions implicit in the protective process. In addition, the provision for a preliminary report within seven days and for follow-up reports at regular intervals keeps the state register fully informed and up-to-date on the handling of reports. This provision was designed to permit the register's administrators to develop forms which—by their structure, the questions asked, and their timing—would help structure protective workers' decision making.

Other Professionals and Agencies. The protective service investigation is the first step in a multifaceted process that should involve a full range of community resources. After investigating and evaluating the family, the protective worker's role is often that of a facilitator—determining the needs of the family, locating the appropriate community resources, and preparing the family for referral for treatment.

In order to help strengthen family life and prevent further maltreatment, the CPS worker must have access to various counseling and concrete services designed to modify the specific psychological and environmental conditions that lead parents to

abuse or neglect their children. Needed services may include psychiatric care; individual or family counseling; group therapy; Parents Anonymous; day care or babysitting; family planning; the services of homemakers or visiting public health nurses; 24-hour comprehensive emergency services; parent education; lay therapists or parent aids; short- or long-term foster placement; job counseling, training, and referral; or the provision of transportation or adequate housing.

Obviously, CPS cannot provide all these services directly. To attempt to do so would be a costly duplication of services already available in the community. To be effective, child protection and family rehabilitation must be seen as a community process as well as a community responsibility.

The abuse and neglect of children is a problem that cannot be managed by one discipline alone. A single case may involve social workers from both a hospital and the public child protective agency, a public assistance caseworker, one or more doctors, a psychiatrist or psychologist, both hospital and public health nurses, police, lawyers, a juvenile or family court judge, the child's schoolteacher, and any of a number of other professionals. However, the interdisciplinary nature of case management frequently proves to be a problem because of lack of coordination among those involved.

One prime obstacle to coordination is the lack of effective communication among professionals. The various people who might break through the walls of isolation surrounding abusive and neglectful families, who might help them to learn to trust, are themselves often isolated within their own disciplines and agencies. As a result, professionals in one field are seldom aware of the objectives, conceptual bases, ethics, and problems of other disciplines. Whether in the field of social work, medicine, psychology, or law, professionals in general are confined by traditional perceptions of role, misinformation about colleagues in other disciplines, and the lack of a common language in their efforts to work together effectively.[7] No matter how well-intentioned the people in individual agencies are, antagonisms, competition, and hostilities can develop across agency lines.

As the family is referred from agency to agency, each responsible for providing a particular service, responsibility passes from one agency and individual to another. But often no one is responsible for overseeing the process and ensuring that the family receives help.

Drs. Lenore Terr and Andrew Watson followed 10 battered children and their families for two years in order to evaluate the medical, legal, and social work handling of each case. They found that "confusion, delays, poorly coordinated efforts, and failure by agencies and individuals to assume responsibility for appropriate action produced serious emotional stresses to already traumatized youngsters." [8] It has been suggested that our system of service delivery in cases of abuse and neglect may be "rebrutalizing" rather than helping the parents as well as the children.[9]

An overview of this system in a typical community would likely show it to have numerous gaps and overlaps among the available resources. Needed services are often lacking or scarce. Those available tend to be isolated in public welfare departments or fragmented among separate, specific programs of child health, mental health, and social welfare. Rather than resembling a connected chain of service to families, community resources exist more often than not as isolated pockets of activity.

Within this system, families inevitably "fall through the cracks." Continuous referrals produce critical delays in services as well as frequent and often dangerous losses of information. With perhaps three to eight agencies involved in a particular case, there are three to eight separate intake interviews that the family must undergo; three to eight or more individuals who must become acquainted with the case; three to eight separate sets of forms to be completed; and three to eight separate filing systems containing possibly inconsistent information about the case.

The constant shifting of agencies and personnel, coupled with repeated intake interviews, can be confusing, threatening, and annoying to the parents and children. It makes worker-client relationships difficult, sometimes impossible; and it may be at least part of the reason behind parents not following up on referrals, failing to keep appointments for treatment, or simply moving to another city or state.

While diversity may theoretically encourage creativity, the present fragmentation of responsibility and patchwork delivery of services both limit the vision of individual professionals and stifle meaningful assistance. Unable to cope alone with all of a family's needs, professionals unwittingly tend to assume a kind of "tunnel-vision" approach to cases. As Dr. Richard Galdston notes, the involved agencies typically set themselves in "positions of polar opposition, with one group identified with the child, another with the parent, and a third with the state and the law." [10] Each agency specializes in helping families with certain kinds of problems, rather than in helping families.

Even if a professional engaged in counseling a family is painfully aware of a concrete problem they have, he or she may be as impotent as the family in obtaining the needed service. A social worker in a clinic or hospital, for example, may spend frustrating hours trying, without success, to obtain adequate housing, day care, or jobs for client-families. The struggle to obtain services wears down professionals' energy and incentive, to say nothing of its demoralizing effect on the families in need of the services.

It would be simplistic to blame the administrators of service agencies and institutions for allowing these problems to persist. As Dr. Vincent Fontana suggests, we all have a share in the blame: "We as a people have come to rely on our institutions to think and act for us; and our institutions—not just our buildings and organizations and public bodies but our principles, concepts, laws, ideals, and systems—are badly administered. We have come to rely on them to let us down. And they do." [11]

Providing the necessary services, choosing among them according to the needs of the family, coordinating them at the administrative level to prevent conflicts and gaps, and coordinating them at the case level to prevent families and their individual members from "falling through the cracks"—these functions are beyond the capability of any one professional or discipline. In the absence of community-wide coordination, they are equally beyond the capability of all our institutions combined. Coordination has to come from within the community. And unless it does, the community will continue to be an environment in which the abuse and neglect of children can flourish.

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For more information about child abuse and neglect, contact:

- The American Humane Association, Children's Division, P.O. Box 1266, Denver, Colorado 80201. Ask for the association's *Publications on Child Protection* (request price list).
- The National Center for the Prevention and Treatment of Child Abuse and Neglect, University of Colorado Medical Center, 1001 Jasmine, Denver, Colorado 80220.
- NIMH Communications Center, Rockville, Maryland 20852. Ask for *Selected References on Child Abuse and Neglect.*

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